Provider Insider

Alabama Medicaid Bulletin **January 2001**

The checkwrite schedule is as follows:

01/05/01	01/19/01	02/09/01	02/23/01	03/09/01	03/23/01	04/06/01	04/20/01	05/04/01
05/18/01	06/08/01	06/22/01	07/06/01	07/20/01	08/03/01	08/17/01	09/07/01	09/14/01

As always, the release of direct deposits and checks depends on the availability of funds.

Governor Siegelman and Medicaid Introduce

Governor Don Siegelman launched "Smile Alabama" October 31 with a press release and letters to Alabama dentists encouraging each licensed dentist in Alabama to accept one new Medicaid patient each week. "I am committed to ensuring the well-being of every child in Alabama," Governor Siegelman said. "This program is critical to the overall health of children, and I encourage dental providers throughout the state to participate in this worthwhile endeavor."

The recent rate increase implemented on October 1 is only the first step in an aggressive outreach initiative designed to provide support for dentists and to educate recipients on the importance of good oral health. The agency is hopeful that this initiative will increase access to oral health care for the children in this state. "We believe that together we can make a difference in the health care of Medicaid children," stated Medicaid Commissioner Michael Lewis.

The "Smile Alabama" campaign will be instrumental to other initiatives being undertaken. The State of Alabama has been selected to participate in the NGA Center for Best Practices Policy Academy for State Officials on Improving Oral Health Care for Children. Alabama was one of eight states selected from twenty-eight states submitting proposals. It is the intent of the Academy to provide each state with expert faculty and technical assistance. Each state is expected to develop a statewide strategic plan to address oral health access issues and to then implement it.

Dentists with questions about programs being instituted by the Alabama Medicaid Dental Program should call 334-242-5997 for additional information. An EDS or Medicaid representative will contact or visit every dentist enrolling in Medicaid. Dental providers experiencing problems in resolving claims issues or with policy questions should also call this number. Please encourage your local dentists to contact us and obtain information about becoming a part of the Medicaid program and caring for our children.

In This Issue...

Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Dept.*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other _____*

Patient 1st Referrals for Certified Emergencies

Based on several recent inquiries, please find below Agency policies regarding care in the emergency room for recipients enrolled in the Patient 1st Program:

Certified Emergency Care

- Hospitals and physicians who provide outpatient certified emergency services are not required to have a referral from the PMP. **Note: Care provided in an office setting is not considered emergency care.**
- As required by the Balanced Budget Act of 1997, the Alabama Medicaid Agency recognizes the "prudent lay person" definition of emergency care. This definition is as contained in the Balanced Budget Act of 1997 and further defined in the State Medicaid Manual Letter dated February 20, 1998. **Certified emergencies do not require a PMP referral for the hospital or the attending physician(s).**

Certified Emergency:

An emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part.

- In determining whether a claim should be submitted and documented as a certified emergency, the parameters listed below should be considered:
  1) The case should be handled on a situational basis. Take into consideration the person presenting, their background, extenuating circumstances, presenting symptoms, time of day, and availability of primary care (e.g., weekend, night or holiday).
  2) Determine whether the presenting symptoms as reported would be reasonably expected to cause the patient to expect that a lack of medical attention could result in an unfavorable outcome.
  3) Document why this case is a certified emergency. Documentation does not need to be extensive rather should be enough to justify the certification.
  4) If not an emergency, do not certify the visit as such. Note that follow-up care should not be certified as an emergency (i.e. physical therapy, suture removal, rechecks, etc).
  5) Ancillary or billing staff are not permitted to certify. Certification must be done by the attending physician.
  6) Children or adults brought to the emergency department for exam due to suspected abuse or neglect may be certified by virtue of the extenuating circumstances.
- All related services for the emergency condition, including those provided by a specialist, may be billed fee for service directly to EDS without a referral. For example, if a child is seen in the emergency room for a broken bone and an orthopedic physician is called in to set the bone and apply a cast, the orthopedic physician should consider his service as part of the certified emergency condition and bill accordingly. The physician must still certify the services as an emergency and the services must be performed in the outpatient setting (place of service 22) on the same date of service. Note that follow-up care should not be certified as an emergency (i.e. physical therapy, suture removal, rechecks, etc.).

(This story is continued on Page 3)

Billing Information for Well Baby Coverage

When billing for well baby coverage, it must be provided within eight weeks of the birth to use procedure code 99432 with diagnosis code of V202. As usual, do not use decimal points in the diagnosis code field.

Providers Should Not Add Zeros to Diagnosis Codes

With the implementation of the new computer system, you do **NOT** have to add zeros to a diagnosis code. Simply use the furtherest subclassification as appropriate. If you are billing for a normal well child check-up, use "V202" for the diagnosis code. You do not use decimals in the diagnosis code block when filing claims to Medicaid.

Medicaid Changes in Hospital Outpatient Billing

Effective for date of service November 1, 2000 and after, Medicaid will be able to process outpatient crossover claims using Medicare's claim data tapes from Blue Cross / Blue Shield of Alabama. Claims for dates of service prior to November 1, 2000, should be filed hard copy or electronically by the provider to EDS using current billing procedures. For claims with dates of service November 1 and after, providers should wait 45 days from the Medicare paid date to allow time for claims to process. If after 45 days, claims do not appear on the Medicaid EOP, the provider should file hard copy or electronically dir-ectly to EDS using the Institutional Medicaid/Medicare Related Claim Form (Form 341).

www.medicaid.state.al.us

Billing Changes for DME Providers

Effective October 1, 2000, Medicaid began reimbursing Durable Medical Equipment providers for Extra Heavy Duty Wheelchairs. These wheelchairs accommodates weight capacities up to 600 lbs. Medicaid covers these wheelchairs as a purchase by using Medicare's procedure code K0007.

Effective October 1, 2000, Medicaid also began reimbursing Durable Medical Equipment providers for the Roho Cushions for the Extra Heavy Duty Wheelchair. This wheelchair cushion is covered as a purchase by Medicaid using Medicare's procedure code K0108.

Medicaid will use the established prior authorization criteria for the Extra Heavy Duty Wheelchair and Roho Cushion, but we will add weight, width and depth specifications. Individuals approved for these items must be fitted and measured for wheelchair and cushion by the Durable Medical Equipment company providing these services.

Effective November 1, 2000, Durable Medical Equipment (DME) Providers of diabetic equipment and supplies who can provide mail order services are allowed to provide these supplies statewide. Medicaid's current policy only allows DME providers to provide equipment, supplies and appliances to recipients living in adjoining counties. This policy will still apply for all services provided with the exception of the diabetic equipment and supplies. These services may be provided by any enrolled Medicaid DME provider offering mail order services of diabetic equipment and supplies. These providers will also offer free replacement of non-functioning diabetic glucose monitors. This updated policy will ensure that all elderly or disabled recipients who are in need of diabetic supplies, and are without any means of transportation will have adequate access to them.

Effective December 1, 2000, Medicaid began reimbursing for oxygen therapy for adults in the home. See Provider Notice 00-22 for further details.

Patient 1st Referrals for Certified Emergencies

Continued from Page 2

- In order to receive payment, there must be an "E" indicator in the appropriate claim block (HCFA 1500 - block 24 I and UB92 – block 78). Refer to the *Alabama Medicaid Provider Manual* for further instructions.
- Providers should split bill for dates of service and place of service for services rendered that are non-certified emergency services. Non-certified emergencies will still require a referral from the PMP.
- Medicaid will be reviewing these claims retrospectively for appropriateness.

Non Emergency Care

- Under COBRA law, hospitals are required to perform a medical screening examination (MSE) on each patient who presents to the Emergency Department. Once the MSE has been performed and it has been determined that the patient does not have an emergency medical condition, then the hospital may inquire about payment status. **If it is not a certified emergency**, the provider must have a referral from the PMP in order to bill for services provided to a recipient in the Patient 1st Program.
- If the patient is enrolled in the Patient 1st program and it has been determined that the patient does not have an emergency medical condition, the hospital has several options:

  1) Tell the patient that they do not have an emergency medical condition and require payment to further treat them
  2) Tell the patient that they do not have an emergency medical condition and instruct them to go to their PMP during office hours the next day (if it is after hours)
  3) Ask the patient to contact the PMP for a referral
  4) Contact the PMP for the patient and ask for a referral

Medicaid stresses the importance of coordinating with the PMPs regarding the care of Medicaid recipients in order to preserve the continuity of care and the "medical home" concept of the Patient 1st program. Should you have problems contacting a PMP or have further questions or concerns, please contact the Patient 1st Program at (334) 353-5773.

What's This Thing Called HIPAA?

Health Insurance Portability and Accountability Act (Public Law 104-191), also known as HIPAA, was signed into law on August 21, 1996. The primary intent of HIPAA is to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs. Provisions of HIPAA mandate that the U.S. Department of Health and Human Services adopt standards for all health care information that is electronically exchanged. National standards will be developed for electronic health care transactions, code sets, standard identifiers, and security and privacy of health information. The security and privacy provisions apply to all electronic health data that are maintained, even if the data is not transmitted to other parties electronically.

HIPAA affects all health plans, healthcare clearinghouses and all healthcare providers that transmits any health information in electronic form (such as health claims, healthcare payment and remittance advice,coordination of benefits and health claim status, etc.).

On August 17, 2000, the final rule for national standards for electronic transactions was published in the Federal Register. This rule adopts standards for eight electronic transactions and for code sets to be used in those transactions.

(This story continues on page 8)

New Billing Guidelines for Well Child Check-ups

The following are updated billing codes for procedures that involve well child check-ups (EPSDT):

Effective November 1, 2000, the age that vision screenings will be paid in addition to the well child screening has been changed to three (3) years of age. Please note that for hearing, the age will still be 5 years of age. Please ensure that this policy is incorporated in your facility's policy regarding well child check-ups (EPSDT).

Effective immediately, TB Skin Tests are no longer required annually when performing well child check ups. Please refer to Appendix A in your provider manual for specific guidelines. Please ensure that this policy is incorporated in your facility's policy regarding well child check ups (EPSDT).

Effective January 1, 2000, the pneumococcal vaccine, Prevnar, CPT Code 90669 has been added to the list of covered vaccines under the Vaccine for Children Program (VFC). Please ensure that this policy is incorporated in your facility's policy regarding VFC.

If you have additional questions regarding this information, please call Medicaid's Medical Services Outreach & Education at 334-242-5455.

Medicaid Encourages Enrollment in VFC Program

The federal Vaccines for Children Program (VFC) was created to meet the vaccination needs of children from birth through 18 years of age. Participation in this program represents a collaborative effort of the Alabama Department of Public Health (ADPH) and the Alabama Medicaid Agency. Children eligible to receive vaccines provided by the VFC Program include:

- Children enrolled in Medicaid
- Children who do not have health insurance
- Children who are American Indian or Alaskan Native
- Children whose health insurance does not cover vaccines

VFC provider benefits include:

- Ensuring that your patients are vaccinated on time
- Controlling who you see in your practice
- Reimbursement of $8 per dose for the administration fee from Medicaid
- Simplified provider enrollment, eligibility screening and vaccine ordering

Enrolling in the VFC Program is simple. Contact the VFC Program at (800) 469-4599 or visit the ADPH web site at www.alapubhealth.org/immunization. Remember, enrolling in the VFC Program is separate from enrolling in the Alabama Medicaid Agency Program and requires completion of a different application form.

(This story continues on page 6)

REMINDER

Patient 1st Providers

Requests to close provider files must be sent to EDS, **30 days prior to the closure date indicated on the request**. The request for closure should include **the provider name, provider number and what action is to be taken regarding the patients assigned to the provider. Closure requests must be received before the 20th of each month**. If the request is not received and processed before the 20th of the current month, the patients will not be assigned to another provider for the following month. If you have questions regarding disenrollment from the Patient 1st Program, you may contact EDS Provider Enrollment Department at (888) 223-3630.

Plan First Program is Limited to Birth Control Services and Supplies

The Plan First program is limited to birth control services and supplies only. This includes all currently available family planning methods, outpatient tubal ligation, doctor/clinic visits (for family planning only) and certain screening tests, such as the HIV test. **Plan First does not pay for any other medical services.** For a complete list of covered services, you may contact Leigh Ann Payne, Program Manager, Plan First Program, at 334-353-5263.

In order to determine what type of eligibility a patient has, it is the responsibility of the provider to verify a patient's eligibility for the date(s) of service. Failure to check eligibility may result in a patient receiving non-covered services or getting family planning services from a provider not enrolled in Plan First. In either case, claims for non-covered services or providers will be denied. If the recipient is enrolled in the Plan First Program, eligibility will indicate Aid category 50, family planning services only.

Depo-Provera Billings Need to be 13-Weeks Apart

Please note that according to the 2000 PDR (page 2435), Depo-Provera is recommended to be administered at 3 month (13-week) intervals. Please schedule your family planning patients accordingly to prevent claims from denying. The Provider Manual incorrectly states in appendix C- Family Planning that the injection can be given up to 1 week before the end of the 13-week period. Currently, the system will not allow reimbursement for services earlier than 13 weeks, and this is being addressed. Until further notice, please make appointments for Depo injections at least 13 weeks apart.

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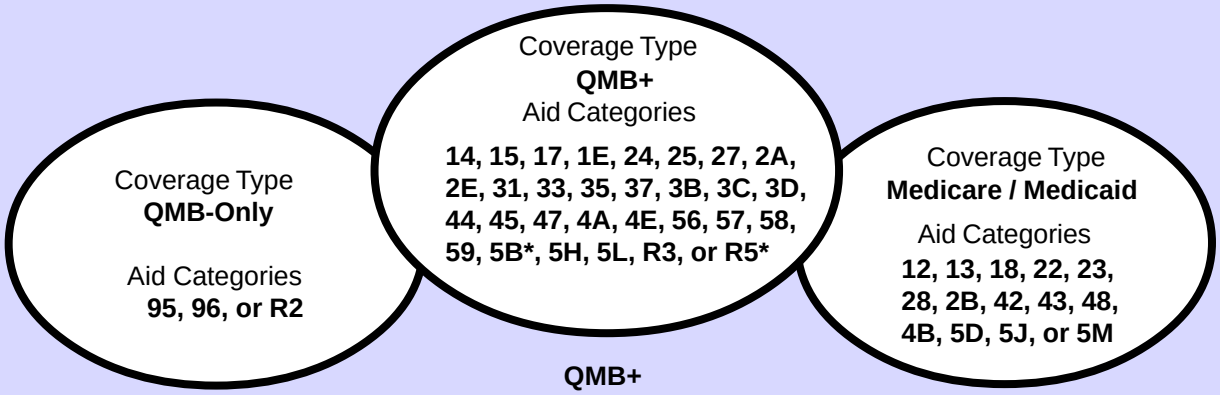
How to Determine if a Recipient has Medicare and Medicaid?

When you verify the recipient's eligibility, the recipient aid category will identify a recipient as eligible for both Medicare and Medicaid. There are three different types of Medicare and Medicaid eligible recipients for which Medicaid is responsible for the deductible and/or coinsurance amounts.



QMB-Only

QMB-only recipients are eligible ONLY for the deductible and/or coinsurance amounts for services covered by Medicare. They are not eligible for any straight Medicaid covered services. In other words, if Medicare covers the service, Medicaid will consider payment of the deductible and/or coinsurance amounts. Premiums and copayment will be considered if the recipient is enrolled in a Medicare HMO that is not contracted with Medicaid.

QMB+

QMB+ recipients are eligible for the deductible and/or coinsurance amounts for services covered by Medicare PLUS any eligible straight Medicaid services that are not a covered service by Medicare. For example, prescription drugs are not normally covered by Medicare, but are covered by Medicaid. Therefore, a QMB+ recipient is eligible for prescription drugs.

*** Medicaid services for these recipients are limited to pregnancy-services only.**

Medicare / Medicaid

Medicare/Medicaid recipients are eligible for the deductible and/or coinsurance for services covered by Medicaid. If a deductible or coinsurance amount is due and Medicaid does not cover the service, Medicaid will not pay the deductible or coinsurance. Examples of services covered by Medicare but not covered by Medicaid are services provided by podiatrists, psychologists, speech and occupational therapists, and chiropractors.

For more information refer to the *Alabama Medicaid Provider Manual*, chapter 3, Verifying Recipient Eligibility.

Cardiac Rehabilitation Added As a Covered Service in the Outpatient Setting

Effective December 1, 2000, cardiac rehabilitation will be a covered service when performed in the outpatient setting. Please ensure that the following policy is incorporated in your facility's policy regarding cardiac rehabilitation:

- Medicare will require that certain conditions be met in order for a hospital-based outpatient cardiac rehabilitation clinic to provide services.
- Medicaid coverage of a cardiac rehabilitation program will be considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician and:

1. Have a documented diagnosis of acute myocardial infarction within the preceding 12 months, or
2. Began the program within 12 months of coronary bypass surgery, or
3. Have stable angina pectoris. Evaluation of chest pain must be done to determine suitability to participate in the cardiac rehabilitation program.

- The frequency and duration of the program are usually three sessions per week in a single 12-week period. Coverage for continued participation in cardiac exercise programs beyond a single 12-week period will be allowed only on a case by case basis. More than 36 cardiac rehab services a year will require prior authorization by Medicaid.
- Coverage may be extended with sufficient documentation that the patient has not reached the exit level, but will not exceed a maximum of 72 visits annually.
- Each exercise session must include **at least one** of the following:

1. continuous cardiac monitoring during exercise, and EKG rhythm strip with interpretation and physician's revision of treatment
2. examination by the physician to adjust medications or for other treatment changes.

- No more than one EKG stress test with physician monitoring at the beginning of the exercise program with a repeat test in three months is reasonable and necessary. The medical necessity for stress tests in excess of the two allowed must be clearly established in the recipient's medical records.
- A physician must be immediately available in the exercise program area in case of emergency
- Formal patient education services are not reasonable and necessary when provided as part of a cardiac rehabilitation exercise program; therefore, Medicaid will not pay for these services.

One of the following ICD-9-CM diagnosis codes must be used with the appropriate procedure code when submitting a claim for Ischemic Heart Disease:

410.00-410.02	410.40-410.42	410.80-410.82
410.10-410.12	410.50-410.52	410.90-410.92
410.20-410.22	410.60-410.62	412
410.30-410.32	410.70-410.72	413.0-413.9

A person with a condition influencing their health status should use the ICD-9-CM diagnosis code of V45.81. The decimal point is included for ease of reading; however, **DO NOT** use the decimal points in the diagnosis field on the claim.

If you have additional questions regarding this information, please call Medicaid's Medical Services Outreach & Education at 334-242-5455.

PMP Policy Reminder for Non-Established Patient Referrals

Medicaid understands that it may be the policy of a PMP not to issue a referral unless the patient is established. We can appreciate the need to know a patient in order to appropriately manage his or her care. However through Patient 1st, new patients are continually added, - patients which the PMP may not have an established relationship. If a patient who is a new patient or one who has not consulted with the PMP requests a legitimate urgent referral, we suggest that you issue the referral and use this opportunity to schedule a follow-up visit. If the patient refuses to follow-up with a visit to your office at that time, it would be appropriate to refuse further referrals.

Keep in mind that many of these patients have changed their PMP assignment to the physician to whom they are currently seeing or have been seeing in the past. For one month, the patient may be assigned to you as a PMP. If a referral is necessary during this one month, then it can be documented as a billing referral only.

Medicaid Encourages Enrollment in VFC Program

(continued from page 4)

A clinic site must be enrolled with the VFC Program in order to be reimbursed for Medicaid eligible children. In addition, every provider including physicians, nurse practitioners and physician assistants must provide the VFC with their Medicaid number for each clinic site enrolled in the VFC.

The VFC Program represents an exciting opportunity for Alabama to improve the health status of its youngest residents by reducing the incidence of vaccine-preventable diseases statewide. Medicaid encourages you to join us.

EDS Provider Representatives

G R O U P 1

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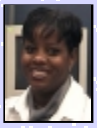

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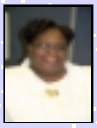

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CRNA
EPSDT (Physicians)
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Physicians
Optometric (Optometrists and Opticians)
Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology

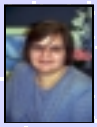
North: Bryan Murphy and Tasha Mastin

Bibb, Blount, Calhoun, Cherokee, Chilton, Clay, Cleburne, Colbert, Coosa, Cullman, DeKalb, Etowah, Fayette, Franklin, Greene, Hale, Jackson, Jefferson, Lamar, Lawrence, Lauderdale, Limestone, Madison, Marion, Marshall, Morgan, Pickens, Randolph, Shelby, St. Clair, Talladega, Tuscaloosa, Walker, Winston

South: Elaine Bruce and Denise Shepherd

Autauga, Baldwin, Barbour, Bullock, Butler, Chambers, Choctaw, Clarke, Coffee, Conecuh, Covington, Crenshaw, Dale, Dallas, Elmore, Escambia, Geneva, Henry, Houston, Lee, Lowndes, Macon, Marengo, Mobile, Monroe, Montgomery, Perry, Pike, Russell, Sumter, Tallapoosa, Washington, Wilcox

G R O U P 2



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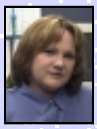

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Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Nurse Midwives
Rural Health Clinic
Therapy Services (OT, PT, ST)
Commission on Aging
DME
Hearing Services
Ambulance
FQHC

Rehabilitation Services
  Home Bound Waiver
Public Health
  Elderly and Disabled Waiver
  Home and Community Based Services
  EPSDT
  Family Planning
  Prenatal
  Preventive Education
Mental Health/Mental Retardation
  MR/DD Waiver

G R O U P 3

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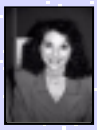

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Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home
Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

One new Provider Representative will be hired in the near future to fill a vacancy.

What's This Thing Called HIPAA? (Continued from page 3)

It also contains specific requirements concerning use of these standards by all health care entities in both the public and private sectors.

Transactions and code sets, these must be in place by October 16, 2002. Even though this may seem like a lengthy time period there is much that has to be done to meet this date. HIPAA is considered to be more far reaching than Y2K because it encompasses enterprise-wide business practices and is not strictly information technology.

Other provisions for standard identifiers, and security and privacy of health information have not been released as of this writing. The security and privacy provisions will apply to all electronic health data that are maintained, even if the data are not transmitted to other parties electronically. Failure to comply with any of these provisions will result in significant monetary penalties.

The first of the final rules have been released and enforcement is mandatory – now the implementation clock is ticking! You need to make yourself aware of the impact that HIPAA will have on you and your practice or business. Suggested activities include attending training sessions for HIPAA, understanding the timelines for implementation of HIPAA compliance activities, viewing WEB sites dedicated to HIPAA, participating in your associations and assessing HIPAA awareness with your vendors relative to the software solution that will be used for HIPAA compliance.

The best place to find the complete text of the proposed and finalized rules and the industry comments on the rules is at http://aspe.hhs.gov/admnsimp. You may visit the HCFA web sites at www.HCFA.GOV for more information on HIPAA issues and links to other web sites.

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